WORLD HEALTH ORGANIZATION

TOBACCO ALERT

OCTOBER 1991

EDITORIAL

"MY NON-SMOKING HERO"

Since 1988, Spirou magazine*, the famous French-language publication for children, has been involved with the large international movement fighting against tobacco consumption.

The first question that the editorial staff considered was this: Spirou has a young readership; how could children, victims of their parents' smoking, act to stop their parents poisoning them little by little? So the editorial staff produced a manual of *"guerilla warfare against smoking"* which, in 32 pages of cartoons, explained to children some of the "detoxification" techniques which are actually used by smokers, and which they could subtly mention to their parents in order to persuade them - also very subtly - to give up smoking. It was like a lesson in parent psychology to help the smoker to stop smoking.

The issue had enormous success. This is why every World No-Tobacco Day since 1989 has been marked by a special issue. In 1990, a little book, charter of the *"first non-smoking generation"*, explained to children why they should **never** start smoking. It attacked from two directions: first it devalued the image of the smoker (*"Smoking doesn't make you look big"*, *"Smoking is for posers"*), and secondly it made a direct attack on unacceptable tobacco advertising (*"Smoking doesn't go with the outdoor life"*, *"Smoking is not adventure"*). This year, a warning poster and figures and comments about tobacco (based on WHO documents) are to be found in the centre pages of the issue for World No-Tobacco Day.

* *Spirou magazine was awarded a Tobacco or Health medal by WHO in 1991 for its work in targeting young people.*

The editorial staff of Spirou are convinced that these campaigns have been so successful for three reasons:

- the first is that they came at a time when an immense wave of opinion against smoking was progressively changing behaviour; they formed part of a general movement for changing attitudes towards tobacco, a universal movement;
- the second is that by speaking about this subject humorously (the humorous cartoons form the magazine's brand image), Spirou has found a form of expression that can easily be understood by children, and that is complementary to the didactic or dramatic approach that others have to use to warn against the dangers of smoking;
- the third is that the humour has never been unjustified. From the very beginning, the magazine had solid documentation which provided a serious base for the humorist, as a result of collaboration with official organs, in particular the Federation against Respiratory Disease and for Health Education, which coordinates World No-Tobacco Day in Belgium.

Because of this creditability, the message *"I have decided to stop before starting"*, championed by little Spirou, was pinned up on the wall of schools, hospitals, doctors' waiting rooms, children's bedrooms, ... and the badge of the first non-smoking generation, also with a picture of little Spirou, was pinned on to clothing.

Patrick Pinchart
Editor Spirou Magazine

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EPEDEMIOLOGY

SMOKING AS A CAUSE OF CANCER

Epidemiological research has repeatedly implicated cigarette smoking as a leading cause of cancer, particularly in developed countries where cumulative exposure has been much greater than in the developing world. The causal relationship with lung cancer is well known. Indeed, in populations where cigarette smoking has been widely prevalent for several decades, 90% or more of all lung cancer cases have been directly attributed to smoking. In addition, smokers are at substantially higher risk of dying from other sites of cancer, including the lip, oral cavity, pharynx, oesophagus, larynx, bladder and kidney, among others.

In their classical study of the causes of cancer in the United States of America, Doll and Peto used estimates of excess mortality risk in a smoking compared with a non-smoking population of American adults to estimate the amount of cancer mortality in the United States in 1978 attributable to tobacco consumption in the past. Overall, they concluded that in 1978 about 30% of all US cancer deaths were due to tobacco, with a marked sex difference (43% of male cancer deaths, 15% of female cancer deaths), reflecting the very different history of consumption for the sexes. Furthermore, Doll and Peto concluded that this percentage was rising and suggested that by the mid-1980s, about one-third of all US cancer deaths would be attributable to tobacco.

Subsequent investigations of the proportion of cancer deaths due to tobacco use have tended to assume that these proportions are applicable in other populations as well. Clearly, however, the proportion of all cancer deaths attributable to smoking will vary according to the relative importance of lung cancer among all cancer deaths; in general, the higher the lung cancer rate, the greater the proportion of smoking-induced cancers.

WHO has recently developed comprehensive estimates of smoking-attributable mortality by age, sex and cause of death for the developed countries where reliable cause of death statistics are available. These estimates allow one to trace the evolution of the epidemic in these countries since 1965 and are based on the estimated excess mortality risk of smokers compared with non-smokers (as observed in the United States), suitably scaled to allow for the different cumulative exposures (i.e. the *"maturity"* of the epidemic) in different populations. This scaling was in turn based on the level of the lung cancer mortality rate, used as a marker of the probable impact of smoking in a population. That is, in populations where the lung cancer mortality rate is high, it is likely that smoking-attributable mortality from other diseases, such as the vascular diseases and the chronic obstructive lung diseases, would also be substantial. Conversely, in populations where the lung cancer death rate is still comparatively low, it is unlikely that smoking-attributable mortality from other diseases is yet very significant. This is the case, for example, for women in countries such as France, Portugal and Spain. However, the very high prevalence of young female smokers in some of these countries points to a major epidemic of smoking-related deaths in the next few decades if current smoking patterns continue among women who are now young.

On the basis of these estimates, WHO has prepared a table of proportionate cancer mortality due to smoking as a function of the lung cancer mortality rate. The table has been derived from the experience of 32 developed countries (all of Europe, and including Australia, Canada, Israel, Japan, New Zealand, the United States and the USSR), using data for 1985 or the nearest available year. The table gives the **average** percentage of all cancer deaths due to smoking within a given range of the lung cancer mortality rate as measured by either the age-standardized death rate or the age-specific death rate at ages 55-64 years. Since the rates for males and females were essentially non-overlapping, the proportions are shown separately for males and females. Although the relationships have been derived on the basis of 1985 data, it is unlikely that the estimates would be significantly higher in the early 1990s in view of the relative stability of the distribution of cancer deaths by site in these populations. It should also be emphasized that these relationships are applicable only in populations where cancer rates are not substantially influenced by other forms of tobacco use, such as chewing, and where the contribution of risk factors other than smoking differs markedly from the United States population which was used as the reference. Thus, for example, the proportions would not apply in those populations where other factors such as indoor air pollution might be expected to substantially influence the lung cancer mortality rate.

With these caveats in mind, smoking is estimated to cause almost half (47%) of all cancer deaths among men in populations where the lung cancer death rate at ages 55-64 years is in excess of 250 per 100 000, or where the overall lung cancer death rate (age-standardized on the *"European"* standard population age structure) is in excess of 100 per 100 000, e.g. Belgium. This proportion falls, on average, to 43% in countries where the overall male lung cancer mortality rate is in the range 80-99 per 100 000 (age-specific rate 200-249 per 100 000), declining progressively to 24% in countries with the lowest male lung cancer death rates, i.e. between 35 and 49 per 100 000 (i.e. death rate ages 55-64 years is less than 150 per 100 000). Among women in countries such as Denmark, the United Kingdom, and the United States, where the overall lung cancer death rate already exceeds 20 per 100 000 (i.e. age-specific rate at 55-64 in the range 50-99 per 100 000), about 15% of all cancer deaths are, on average, attributable to smoking. This proportion is expected to rise dramatically as the epidemic becomes increasingly evident among women.

Overall, in the developed countries about 42% of male cancer deaths each year are attributable to smoking. For women, the average is currently about 8% but rising.

Estimated percentage of cancer deaths due to smoking

Age-standardized lung cancer mortality rate (per 100 000)	Age-specific lung cancer mortality rate (per 100 000) at ages 55-64 years	Average % of all cancer deaths attributable to smoking
	MALES	
≥ 100	≥ 250	47
80-99	200-249	43
50-79	150-199	38
35-49	75-149	24
	FEMALES	
20-34	50-99	15
10-19	25-49	5
< 10	< 25	2

SOCIETY

SMOKING AMONG JUNIOR SECONDARY SCHOOL CHILDREN IN HONG KONG IN 1990

This territorial self-reported study, carried out in March 1990 on behalf of the Hong Kong Council on Smoking and Health, is the first attempt of its kind in Hong Kong to ascertain the extent of cigarette smoking among teenagers in the territory. The study also examines cigarette smoking in relation to motivation, values and health information, the smoking behaviour of family members and peers, and alcohol consumption and its role in leading to the abuse of other psychotropic substances.

The study yielded a total of 30 schools with 90 classes of students and 3 337 valid cases were used for analyses. In terms of age, the mean age of the students was 14.5 years with a standard deviation of 1.2. In terms of sex, 49.3% of the respondents were male and 50.7% were female. In terms of housing, 48.8% of the respondents lived in public housing, 48.0% in private housing, and 3.1% in other types of housing.

By the age of 13 years, about 20% of the young people surveyed had already tried smoking, and by the age of 16 years 47.1% had experimented with smoking. For all age groups, about 33% had tried smoking. In terms of sex, by the age of 16 years, more than half of the boys had tried smoking compared to about one-third of the girls. Among all young people who had tried smoking, about 19% of them tried their first cigarettes when they were under seven years. The vast majority of them tried when they were between the ages of eleven and fourteen years.

Approximately 75% of the respondents smoked their first cigarette out of curiosity. However, there are other reasons, including 1. imitating friends and close family members – 9.0%; 2. naivety – 6.4%; and 3. boredom – 2.0%. Boys and girls do not vary much in terms of the motivation leading to the smoking of their first cigarettes.

About 20% of the young people specifically named home as the place where they obtained their first cigarette. More significantly, 51.9% of the first cigarettes smoked by young people were mainly given by friends who are also likely to have got their cigarettes from home. A large proportion of first cigarettes was generously given by parents, grandparents and siblings, making a total of 11.8%. Neighbours also contributed, amounting to 10%.

By the age of 13 years, 5.3% of young people smoke regularly. The trend increases to 15.6% when they are 16 years. About 11% of the youth groups of both sexes smoke regularly. About 14% of the male juvenile population smoke, compared to 8% of the same female population. Significantly, more girls commence smoking between the ages of 13 and 14 years.

Today, 34.8% of young people smoke cigarettes out of curiosity and for fun, while about 22% smoke because they admitted that they are now addicted to the habit. Other reasons for smoking include boredom, imitating peers and family, and to look fashionable, accounting for 13.0%, 10.3% and 7.0%, respectively. About 9% of the young people surveyed said that they smoke for no specific reason. Boys tend to think that smoking is fashionable or that the habit may attract the opposite sex. They are also more susceptible to peer pressure and are slightly more vulnerable to becoming addicted to the habit. Girls tend to smoke when they feel bored or as as a way of alleviating pressure; they also tend to smoke for no specific reason.

At present, 57.3% of youngsters say that the main source of cigarettes is shops. Contrary to their first cigarettes, only 4.5% get their cigarettes from home. Quite a large proportion, 36.1%, are given cigarettes by friends, many of whom are likely to have bought them in shops. On average, boys smoke 26 cigarettes in a week compared to 20 cigarettes for girls.

Parents who smoke are more likely to have children who smoke. Fathers who smoke are twice as likely to have children who smoke than is a father who does not smoke. The ratio increases to more than three times for mothers, four times for brothers, and five times for sisters. Of young people who smoke, 67.5% admitted that both of their two best friends are also smokers; 21.1% said one of them, and only 11.4% said none of them. Young people living in public housing are more prone to smoking than are their counterparts living in private housing. If young people are categorized according to housing types, it is found that 12.5% of the youngsters living in public housing are habitual smokers, compared to 8.9% of those in private housing.

The two main reasons offered for not smoking are the bad odour (48.2%) and the addictive nature of cigarette smoking (51.0%). Other reasons, amounting to 37.4%, are (a) bad appearance; (b) effect on others; and (c) waste of money.

About 90% of the respondents admitted that cigarette smoke (e.g. in restaurants and on buses) makes them feel uncomfortable; this broke down to 92.8% for the non-smokers and 64.7% for the smokers. Young people who smoke also have a much higher incidence of alcohol consumption.

These results emphasize the importance of prevention programmes that address the issue of smoking in the home.

NEWS BRIEF

PROTECTION OF CHILDREN

The Governments of Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates have imposed, by legislative means, a ban on chewing tobacco. Moreover, they have adopted measures against other practices which might encourage young people to consume tobacco, such as a ban on the import of products which might promote cigarette smoking by children, e.g. sweets designed to look like cigarettes or cigarette packets. Retail outlets are, of course, prohibited from selling cigarettes to minors.

READEX

WORLD NO-TOBACCO DAY, 31 MAY 1991

"PUBLIC PLACES AND TRANSPORT: BETTER BE TOBACCO-FREE"

World No-Tobacco Day 1991 was truly a day of celebration as called for by the World Health Organization, and Member States had many reasons to claim victory: by the end of 1990 no fewer than 63 countries had passed laws to control smoking. In addition, statutes to control smoking in public places and transport were adopted at the local level in most countries, provinces, or townships. World No-Tobacco Day 1991 was also an opportunity to adopt further regulations and to widely publicize information to convince legislators of the importance and the possibility of making smoking in public places both socially unacceptable and against the law.

The fact that the importance given to the celebrations in all countries extended from the governmental level (messages from Presidents and Ministers), to the local level (nongovernmental organizations, transport authorities, taxi companies etc.) demonstrates that a very large cross section of the population was exposed to the WHO message on tobacco-free public places and transport.

The following provides highlights of the information already received by **Tobacco Alert;** a more detailed account can be found in the advisory kit (attached) for World No-Tobacco Day 1992.

Media coverage for the celebration of World No-Tobacco Day 1991 appears to have been more extensive than in previous years and more detailed in content. A timely campaign of press conferences held by ministries of health, governmental and nongovernmental organizations, WHO officials at headquarters, in the regional offices and in individual countries, undoubtedly contributed to this increased interest.

... in the Philippines

From Cost Rica to the Philippines, from Pakistan to Thailand, the press echoed the concern of WHO and reproduced, completely or in part, the WHO Director-General's appeal which called for all those who smoke or chew tobacco to break this harmful and wasteful habit.

The press also emphasized the dangers of passive smoking, a relatively new concern for some countries. The main theme of the celebration was also picked up in most official communications for the day, such as the messages of the Minister of Health of Zaire and the Director-General of UNESCO, and by Dr Al-Awadi who, in accepting a Tobacco or Health medal at a ceremony in WHO headquarters, said *"We should really push and increase the rights of non-smokers and teach our children that we should have the right to say, `please don't smoke'. This is what we should fight for and that is where we will be achieving a real future which we hope is going to be a smoke-free world."*

The banning of smoking in public places also makes economic sense, as underlined at the ceremony at headquarters by an Air Canada official: *"... we have been looking into the benefits [of banning smoking aboard] and I am talking about the benefits from a commercial organization's point of view, not from a health point of view, and from the commercial point of view we can already identify direct savings of about US$ 700 000 per year due to the fact that we don't have to spend time cleaning all those ashtrays .... and also we have been able to extend the deep cleaning exercise which every airline goes through where you look at shampooing your carpets and your curtains and the back of seats and things, by anything from 6-9 months because there is no residual ash around now which you did have in the air ....."*

... at WHO Headquaters in Geneva

On 31 May 1991, once again nongovernmental organizations proved to be prime initiators behind the activities of World No-Tobacco Day. One only has to see some of these actions to realize what a multiple effect nongovernmental organizations can have in the dissemination of information. On the occasion of World No-Tobacco Day

WORLD NO-TOBACCO DAY, 31 MAY 1991

1991, a campaign to prohibit all smoking on international airline flights was launched in dozens of major cities around the world; the American Lung Association, American Heart Association, and American Cancer Society, united as the Coalition on Smoking OR Health; the Canadian Cancer Society, and hundreds of consumer and health organizations joined WHO in supporting the call for smoke-free skies worldwide. The European Bureau for Action on Smoking Prevention (BASP) in Brussels coordinated various celebrations in Europe, such as the press conference on 30 May 1991 organized by seven countries – Belgium, France, Italy, Luxembourg, Portugal, Spain and the United Kingdom – to promote smoke-free flights on airlines throughout Europe.

Material produced by WHO for the day was extensively used, translated and adapted to the needs of individual countries, and in addition various governmental and nongovernmental organizations produced complementary material related to the theme of the day. Amongst the material produced by WHO, specific mention has to be made of the poster which has not only been reproduced in innumerable articles but has also been modified to bear the specific names of countries, organizations, towns and local transport authorities; this was subject to agreement on the design. The poster was also "*pirated*" by several entities who replaced some of the famous buildings depicted on the poster with their own local buildings.

... in Bangladesh

As in previous years all United Nations agencies, and particularly the VIC Centre in Vienna, staged celebrations on World No-Tobacco Day 1991. Furthermore, this year a number of agencies of the UN system used the theme of the day to reinforce and extend their regulations regarding anti-smoking policies at the workplace. A special feature of this year's celebration was the extensive participation of the United Nations information centres throughout the world. They relayed information provided by WHO to individual countries and in a similar fashion transmitted details of events in countries back to WHO.

The impact of such a day should first of all be measured by the number of people who quit smoking on the day and have remained non-smokers thereafter; but also by the number of people who have been protected from passive smoking! Although a few WHO Member States have endeavoured to study this specific impact of World No-Tobacco Days, it is very difficult to measure it precisely; such an evaluation should be encouraged. What could be more easily measured is the legislative measures and the regulations adopted as a result of the campaigns carried out on the theme of World No-Tobacco Day 1991.

The theme chosen for World No-Tobacco Day 1991 may have been particularly easy to publicize and may have attracted the attention and goodwill of local transport authorities, air carriers and national transport authorities, but it appears that the celebration this year has been particularly "*visible*" and that World No-Tobacco Day is proving to be an essential vehicle for the propagation of the tobacco control message.

SOCIETY

GENEVA CANTONAL HOSPITAL BECOMES TBACCO-FREE

"As part of WHO's fight for a society in which non-smoking will be the norm, our Organization is particularly relying on action by health professionals. They should set the example and take active steps to eliminate tobacco from the health services". It was with these words that Dr Abdelmoumène, Deputy Director-General of the World Health Organization, inaugurated the ceremony on 31 May 1991 declaring the Geneva Cantonal Teaching Hospital a *"tobacco-free zone"*.

During the ceremony Mr Guy-Olivier Segond, State Councillor, and the hospital authorities pointed out that a hospital is a place providing care, where everyone's first concern is the health and well-being of the patients; it therefore seemed a self-evident public health measure to provide them with a healthy smoke-free environment. The great majority of the staff expressed similar views in a survey conducted in 1990 by the Hospital's panel on smoking.

Putting this decision into a world-wide context, Dr Abdelmoumène stressed how much the health services are in the public eye: *"in a place where people are endeavouring to fight disease and suffering, how is it conceivable to sell a drug that will ultimately take toll of one quarter of those who use it after all-to-familiar suffering"*.

It is true that some major successes have already been achieved around the world. For example, smoke-free hospitals and health centres are the rule in Finland and many other countries; the sale of tobacco and tobacco products is banned

there. But this is just a first step. Dr Abdelmoumène went on: *"This objective requires not only that WHO should encourage the necessary measures but also that these measures should be taken at the highest level by all health services, whether public or private, and by everyone who, like yourselves, is empowered to take decisions. I welcome the fact that the Geneva Cantonal Hospital is today taking sides with WHO. I have followed with interest the process that has brought you to this point, and I hope that many other hospitals in Switzerland will follow your example. I also hope that this encouragement of abstinence will lead smokers who are admitted to hospital to give up their harmful habit once and for all"*.

Not only is the step taken by the Cantonal Hospital in perfect harmony with the policy and programmes of WHO, but this year it coincided with the topic chosen by WHO for World No-Tobacco Day: *"Public places and transport: better be tobacco-free"*, thus making an outstanding contribution to the celebrations that took place in the Canton of Geneva on 31 May 1991. At the Cantonal Hospital the sign reading *"For a no-smoking hospital"* was inaugurated, and to conclude the event, children from the paediatric wards released coloured balloons into the sky.

Both the Geneva Public Transport Company (TPG) and the General Bill-Posting Company showed their support for the occasion by arranging for the logo *"For a no-smoking hospital"* to be displayed free of charge in all TPG vehicles.

WHO/TOH PROGRAMME

ACTIVITES IN THE AFRICAN REGION

Tobacco or Health programmes in sub-Saharan Africa require special effort. Although the smoking rates are still low compared to those of developed countries, smoking rates are rising in sub-Saharan Africa unlike in developed countries, where they are falling. With little financial and staff resources the World Health Organization endeavours to confront the issue before the situation deteriorates.

Public information and health education are the primary components of the Tobacco or Health programme of WHO's Regional Office for Africa.

A workshop for journalists has been planned by the Regional Office for Africa and will be held in December 1991. One of the topics at this workshop will be tobacco or health. It is hoped that several journalists, having attended the workshop, will go on to inform the public in their own countries of the dangers of tobacco smoking and the need to quit smoking.

Recent discussions between WHO staff and the authorities in Botswana, Congo, Kenya, Namibia, and Zimbabwe have promoted the development of comprehensive school health education curricula which would include tobacco or health. The willingness of senior officials of health ministries in the above-mentioned countries is considered very encouraging.

Legislation is the second mode of action which can be taken to reduce tobacco smoking. Since 1990, a number of countries have enacted legislation which prohibits smoking in public places, including various workplaces. For example, in Nigeria it is illegal to smoke in cinemas, theatres, football stadiums, offices, schools and health units, as well as on public transport. The Government of Mauritius enacted legislation in April 1990 which prohibits smoking while engaged in preparing, serving, or selling food in public places. It is also forbidden to smoke in hospital wards, in classrooms, gymnasiums and swimming pools.

The WHO Regional Office for Africa has distributed copies of the above-mentioned legislation, and other laws and regulations made previously by various countries, to all Member States in the African Region in the hope that they will act as an incentive for countries who have not yet made any developments in this area.

LEGISLATION

CHINA'S LANDMARK TOBACCO LAW

The Standing Committee of the 7th National People's Congress – China's highest legislative body – has just announced approval of China's first-ever tobacco law, which will come into effect on 1 January 1992.

China is the largest producer and consumer of tobacco in the world. The National Prevalence Survey, carried out in 1984 among 519 000 people, alerted the Chinese Government to the fact that 7% of women and 61% of men over the age of 15 years were daily smokers. A second national prevalence survey is envisaged for 1992.

There are 300 million smokers in China and more and more young people are taking up the habit. The main effects of this increase in the rural population (where stroke and chronic respiratory disease are already the commonest causes of premature death) will not be evident until the next century, but in urban males lung cancer is already the commonest neoplastic cause of death. On present smoking patterns, tobacco is likely to become the largest single cause of death in China; of the children now aged 0-19 years in China, about 50 million will eventually, as adults, be killed by tobacco (see **Tobacco Alert** of January 1991).

Over the last decade, China has initiated several conferences and workshops on tobacco control, principally under the auspices of the Ministry of Public Health, the Chinese Academy of Preventive Medicine, the World Health Organization and the International Union Against Cancer (see **Tobacco Alert** of July 1990). There have been several major health education campaigns, and World No-Tobacco Day has been marked since 1988. In 1990 the Government established the national Chinese Association on Smoking and Health to coordinate tobacco control activities throughout China.

The Chinese law may therefore be considered timely. Primarily, it simply regulates many aspects of the state national tobacco monopoly – cultivation, distribution, licensing, manufacture and sales, import and export of tobacco products and machinery, crackdowns on smuggling – but the new law also includes several crucial health provisions:

Article 1

- bans on tobacco advertising on TV, radio, newspapers and magazines

Article 5

- reduction of tar and other harmful substances in tobacco products
- improved health education on the harmful effects of smoking
- bans/control of smoking on public transport and in public places
- advice for young people not to smoke
- bans on smoking by elementary and high school students

Article 18

- printing of tar levels and health warnings on cigarette packs

This landmark law represents the first, albeit giant, step in legislative control of tobacco use, and further legal provisions are planned for 1992. China must be warmly congratulated on taking this important and responsible public health measure.

NEWS BRIEF

SMOKE-FREE HAMILTON

On Tuesday, 27 August 1991, the Council of the Corporation of the city of Hamilton (population of 300 000), Canada's ninth largest city, passed a resolution endorsing the World Health Organization's goal of a smoke-free society by the year 2000.

This resolution was passed during a debate which saw a strengthening of the city's by-law restricting smoking in public places and on public transport, as a contribution to WHO's year of smoke-free public places and transport.

The city of Hamilton, its aldermen and mayor should be congratulated for the wisdom behind this resolution and it is hoped that this step can be furthered by getting other jurisdictions to do the same.

WHO/TOH PROGRAMME

THE WHO/TOH INFORMAL CONSULTATION ON WOMEN AND TOBACCO

"Women are a priority target for the tobacco industry and the draft monograph on women and tobacco will thus help to fill a gap in the present knowledge available on the subject. The production of a well documented paper in this field is particularly timely for stimulating not only policy considerations but also specific programme strategies which in turn will provide a foundation on which to act in individual countries." said Dr J.R. Menchaca, Programme Manager of the Tobacco or Health programme, in opening the Informal Consultation on Women and Tobacco which was held at WHO headquarters in Geneva, from 10-14 June 1991.

The purpose of the meeting was to review a monograph, produced by the Tobacco or Health programme, detailing the patterns of women's tobacco use worldwide, the impact of tobacco use on women's health, and reasons why women start and continue to smoke.

Women smokers are numbered in millions throughout the world, and several million more are addicted to tobacco use in other ways. The number of women smokers grows daily, not only because of the world's fast growing populations, but also because smoking cigarettes is being fostered and encouraged worldwide for commercial gain and, in spite of incontrovertible evidence of the toll of death, disease, and incapacity that is being caused, many governments have remained ambivalent towards solving an equation in which the variables are excise and tax revenue, health and welfare expenditure, and political expediency.

The incidence of smoking-related diseases and concomitant death rates have increased rapidly among women in many developed countries in recent years. In most countries, there are no epidemiological indications of a likely decrease in the near future and the continuing adoption of smoking in these countries gives cause to expect a continuing increase in both disease incidence and death rates. In most developing countries, cigarette smoking, so far maintained at a low level, is being fiercely promoted. As more women fall victim to the habit, the effects will be an inexorable toll on health and well-being; and the impact is such as to prevent the reaching of WHO targets towards *"health for all by the year 2000"*.

Until recently, the effects, scale, and impact of smoking-related diseases had not been as clearly in evidence in women as in men and suppositions that women may be more resistant to tobacco may have arisen. It is now clear, however, that women are not only susceptible to the same tobacco-related diseases as men, but are also affected by other additional conditions that are specific to women.

In the developed countries, where smoking by women is well established, the challenge is twofold: to halt the rapid escalation of the habit that is currently occurring in many places and to register more success in reducing the prevalence and intensity of smoking by women.

There are many areas of the world, particularly in the developing countries, where tobacco use is still at a low level and may as yet even be nonexistent among women. Here is where future disease could be effectively prevented. There is, however, a dearth of knowledge on tobacco use by women in most countries and efforts to obtain more factual information are needed so that countermeasures can be better developed and used more effectively.

While there is a need for further information, there exists a sufficient body of scientific evidence for public health action on tobacco and women not to be delayed. This monograph is thus intended to provide background information on a wide range of aspects of smoking by women and to identify the directions in which action can be taken to curtail and eventually eradicate tobacco use by women and, thereby, prevent worldwide problems of incapacity, ill health and death in untold proportions in the not very distant future.

The target audience of such a monograph would specifically be staff of ministries of health (and in some cases other ministries such as education, labour and social welfare) at decision-making levels, legislators, nongovernmental organizations (NGOs) and universities who will be able to carry out research on the subject and be advocates in the developing world. NGOs involved in activities concerning women should be widely targeted in the book. The aim should be to try to reach not only countries where tobacco or health issues related to women have already been activated, as in several industrialized countries, but also developing countries where concern for the problem has not yet been sufficiently raised.

It is expected that this monograph will be published by WHO in early 1992.

WHO/TOH PROGRAMME

WHO'S IN CHARGE IN WHO?

In the Regional Office for Europe, Dr Tapani Piha has been appointed Regional Adviser for Tobacco or Health. Prior to his assignment to WHO in September 1989, Dr Piha (a specialist in community medicine), worked as a senior medical officer for the National Board of Health, Finland where he mainly worked in the field of tobacco control policies.

This newsletter is issued by the WHO programme on Tobacco or Health (TOH), World Health Organization, 1211 Geneva 27, Switzerland. The text may be freely reproduced and illustrations may be used, giving credit to WHO. Cuttings are requested. Contributions and suggestions to be addressed to Dr C. Chollat-Traquet, Editor. The following have contributed to this issue:

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Design: WHO Graphics

World No-Tobacco Day

World Health Organization

"Tobacco-free workplaces: safer and healthier"

31 MAY 1992

ADVISORY KIT 1992

World No-Tobacco Day

WHO SUPPORT FOR WORLD NO-TOBACCO DAY, 31 MAY 1992

"Tobacco-free workplaces: safer and healthier"

The following information has been compiled to support the celebration of the World No-Tobacco Day. It suggests activities to help promote the transmission of the message "Tobacco-free workplaces: safer and healthier". These activities will need to be adapted to the culture and tastes of every country and every community and to the special conditions and risks of individual industries or companies; they may help generate further ideas and make 31 May 1992 another successful World No-Tobacco Day.

The advisory kit for World No-Tobacco Day, 31 May 1992, contains the following:

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In addition...

to the present information kit, the World Health Organization intends to produce the following items as background material for the fifth World No-Tobacco Day:

- press releases;
- a video (12 minutes) on the theme "Smoke-free work places";
- a press kit, featuring articles, pictures, stickers and posters;
- radio recordings, to be made by various WHO experts on the subject of tobacco control.

If you are interested in any of the above, please ensure that you submit your order in advance (see list of WHO focal points for the day on the last page of this kit).

WORLD NO-TOBACCO DAY, 31 MAY 1992

Message from Dr Hiroshi Nakajima, Director-General of the World Health Organization

Day after day workers who smoke subject themselves to the harmful effects of tobacco; also to the combined effects of indoor air pollution and tobacco smoke. Furthermore, they threaten the health of their fellow workers, who could be the victims of passive smoking.

Decades of effort throughout the world have gradually improved safety at work. Only if these endeavours continue can workers be protected from risks to health inherent in their occupation. This progress should not be marred by the use of tobacco.

It is not acceptable that people who must work to earn their living should be subjected to added risk because of a useless and dangerous habit. Usually employees have little influence on their working conditions and, in particular, little defence against passive smoking, to which they are subjected in the very place where they go to work in order to support themselves and their families.

Work is a necessity, allowing human beings not only to provide for their needs but also to develop their creative skills. It occupies most of an adult's waking time. People have the right to work in a congenial atmosphere, in the cleanest possible air.

Not choking one's colleagues with smoke is a courtesy that often has to be formalized by regulation. It is equally an employer's duty to protect the health of colleagues and employees from risks that include passive smoking. Many legal and juridical measures endorse this obligation, and they reflect not only the risk of disease and death, but also the economic effect of smoking on the employer, in terms of absenteeism, industrial accidents and fires, which are a real menace even in agricultural areas.

The World Health Organization has already appealed successfully to the public authorities and to the civic sense of individuals in regard to smoking tobacco. On 31 May 1992 it will turn to workers and employers. I invite them especially to work with WHO in preparing this event, taking one more step towards a safer and healthier place of work.

Hiroshi Nakajima, M.D., Ph.D.
Director-General

World No-Tobacco Day

What is World No-Tobacco Day?

In view of the scientifically proven dangers of tobacco both for smokers and for non-smokers who inhale smoke produced by others, WHO has committed itself to fighting this menace. World No-Tobacco Day, celebrated on 31 May each year, is intended to discourage tobacco users from consuming tobacco and to encourage governments, communities, groups and individuals to become aware of the problem and to take appropriate action. In 1991, the emphasis was placed on smoking in public places and public transport, with the slogan: "Public places and transport: better be tobacco-free". In 1992, we will concentrate on smoking at work and on the need for combined action by governments, employees and employers: "Tobacco-free workplaces: safer and healthier".

What is the message for 31 May 1992?

The workplace – along with bed! – is the place where people spend most of their lives. So the least they can ask is to be able to breathe healthy air there, unpolluted by tobacco smoke. But as everyone knows this is far from being the case everywhere at present and many non-smokers have to share their office or workshop with one or more smoker colleagues. Working in a cloud of smoke can become a real torment; apart from the well-known harmful effects of passive smoking on the health of non-smokers, the discomfort caused by the smoke of others, already hard to put up with in a public place on a brief visit, becomes quite intolerable at work where people spend eight or more hours a day. Respiratory and other disorders are then likely to be compounded by stress and bad mood, resulting in increased absence from work and ultimately in lower output for the company; however, employers, directors and managers are not always sufficiently aware of this.

On the fifth World No-Tobacco Day, therefore, the aim will be to put across the message that everyone should have the right to work in an environment unpolluted by tobacco smoke. It will also be an opportunity to encourage leaders at all levels to take action. More and more companies are taking appropriate measures at the request of their employees or for economic reasons (see fact sheet). There are not always coercive measures aimed at banning or reducing tobacco consumption: some company managers have found ingenious ways of encouraging people to give up smoking of their own accord. For instance, some companies have started granting extra days of holiday to their non-smoking employees. This is one of a number of examples worth thinking about and imitating.

EVENT PLANNER

How is the message to be conveyed?

The events organized for World No-Tobacco Day lend themselves to media reporting: they can be filmed, discussed in radio interviews, photographed or reported in newspapers and magazines. All the activities – distributing information at the workplace, having main industries and companies observe the day or even declare their premises tobacco-free, displays of posters or photos – can become media events as long as national and local media (television, radio, newspapers and magazines) are contacted in good time. All gatherings in public places or at the workplace can be turned to advantage. The material distributed by WHO should be seen simply as a catalyst, a starting point for local activities whose only limits are the resources and talents of the local organizers. The aim is to inform not only the public but also decision-makers who could help combat smoking, especially along the lines of the year's theme.

Once you have decided what type of event you want to organize to celebrate World No-Tobacco Day, consider how you are going to organize it.

The following questions might be of use:

1

What is our purpose in organizing this event?

2

How can we gain the participation of the greatest number of people?

3

What media representatives – from the press, radio and television – should we contact right now, to tell them about the activities planned for World No-Tobacco Day?

4

What items should we have made: T-shirts, badges, posters, letters for the use of the organizers?

5

How can leading figures in the working community, employees and employers and families help us organize and celebrate World No-Tobacco Day?

6

What celebrities might agree to participate?

7

How could the media help with advance publicity for World No-Tobacco Day?

8

How can the events be organized so as to enable the press to write articles about it or take photographs?

9

How can action be sustained after World No-Tobacco Day in order to create a greater number of tobacco-free workplaces?

10

How can our work for this year's World No-Tobacco Day help us prepare for 31 May next year?

WORLD NO-TOBACCO DAY 31 MAY 1992 "TOBACCO-FREE WORKPLACES: SAFER AND HEALTHIER"

Facts for action

I. Introduction

Tobacco kills at least 3 million people each year worldwide. In countries where smoking has been a long-established behaviour, about 90% of lung cancer deaths, 30% of all cancers and over 80% of cases of chronic bronchitis and emphysema are attributable to tobacco use, as are some 20-25% of coronary heart disease and stroke deaths. Numerous other adverse health conditions including respiratory diseases, peptic ulcers and pregnancy complications are also attributable to smoking. The adverse effects of smoking on pregnancy range from low birth weight to increased incidence of spontaneous abortions, prematurity, still-births and neonatal deaths. Low birth weight is one of the strongest predictors of infant mortality. Other long-term effects on the child include impaired physical and intellectual development. Tobacco used in smokeless forms, e.g. for chewing, snuff taking, etc., is a major cause of oral cancer in countries, mostly in the Indian subcontinent, where the behaviour is widespread. Smoking materials are also a leading cause of many industrial, forest and residential fires and fire-related casualties.

II. Tobacco-free work places: safer and healthier

The combined effect of smoking and occupational hazards has shown that there are significant differences between the morbidity of smokers and non-smokers in many occupations and that the interaction of the two types of hazards increase the risk of many diseases, particularly the chronic obstructive lung diseases, lung cancer, cardiovascular diseases, as well as disabilities. Tobacco smoking is not only dangerous to the smoker but to non-smokers as well. Besides the acute effects of eye and throat irritation caused by exposure to environmental tobacco smoke, passive smoking (see Section IV) increases the risk of lung cancer and possibly of cardiovascular disease in non-smokers. In the face of these threats posed by smoking, there has been increasing pressure for worldwide action to protect the freedom of nonsmokers from the hazards to which they are exposed when smoking is permitted in the workplace or any other public place.

Historically governments, employees and employers have adopted a variety of attitudes on the need and urgency to protect workers from the risks of smoking and passive smoking at work. However, over the past few years, the trend towards tobacco-free workplaces has accelerated and legislation, regulations and methods to liberate workplaces from tobacco have been devised. Featured below are highlights of facts, figures and situations from around the world which call for further action to promote tobacco-free workplaces.

III. Health effects of occupational hazards and smoking

Tobacco consumption is responsible for cancers, chronic obstructive pulmonary diseases and cardiovascular diseases; occupational health hazards are also a cause of mortality and morbidity from similar diseases. Workplace hazards and the dangers associated with smoking at work should not be separated, nor isolated from each other as there are several ways in which smoking and workplace-generated harmful agents can interact on human health (see Table 1).

Table 1

Major examples of interactions between occupation and cigarette smoking in causing disease

Occupation	Exposure	Disease	Smoking-occupation interaction
Asbestos workers, Construction workers and others in contact with asbestos	Asbestos	Lung cancer	Multiplicative
		Chronic lung disease (restrictive, obstructive)	Additive
Aluminium smelter workers	Polynuclear hydrocarbons	Bladder cancer	Additive or multiplicative
Aircraft and mining industry and many others	Noise	Loss of hearing and hearing acuity	Additive
Cement workers	Cement dust	Chronic bronchitis, obstructive lung disease	Additive
Chlorine manufacturing	Chlorine	Chronic obstructive lung disease	Additive
Coal miners	Coal dust	Chronic obstructive lung disease	Additive
Copper smelter workers	Sulphur dioxide	Chronic obstructive lung disease	Additive
	Arsenic	Lung cancer	Additive or multiplicative
Grain workers	Grain dust	Chronic bronchitis, obstructive lung disease	Additive
Organic chemicals	Carcinogens	Cancer of various organs and tissues	Additive or multiplicative
Rock cutters, foundry workers	Silica dust	Chronic obstructive lung disease	Additive
Textile workers	Cotton, hemp, flax, dust	Acute airway obstruction (byssinosis) chronic bronchitis	Possibly multiplicative
Uranium miners and many other miners in radioactive environment	Alpha radiation (Radon)	Lung cancer	Possibly multiplicative
Welders	Irritant gases, metal fume, dusts	Chronic bronchitis, obstructive lung disease	Additive

Elements taken from: Occupational Medecine, Appleton and Lange publishers.

a) Tobacco smoke can modify the risk associated with materials encountered in the workplace, in some cases causing a highly elevated risk

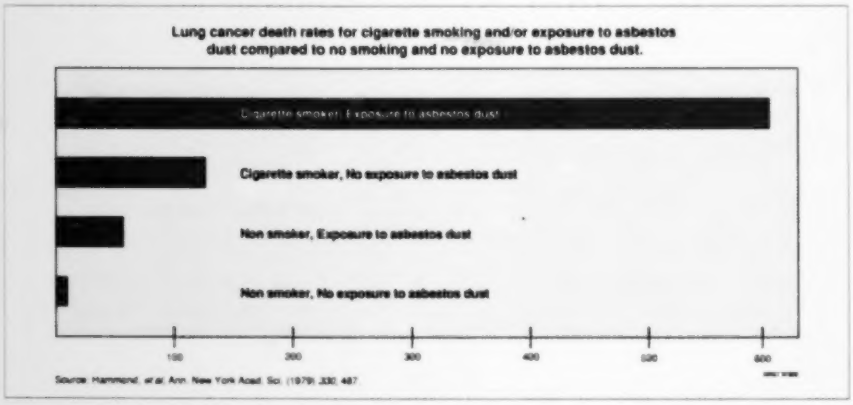
Asbestos dust inhalation causes lung cancer and a form of pulmonary fibrosis known as asbestosis. The combined effect of smoking and inhaling asbestos dust raises the risk of lung cancer to a far higher level than would be expected from just adding together the individual effects of each hazard, as is shown in the accompanying figure, as well as increasing the severity of asbestosis. Asbestos can be a hazard in a wide range of occupations because of its resistance to fire, heat and caustic substances. It is used in building materials, electrical and thermal insulation, fire and safety equipment.

The risk of emphysema and chronic bronchitis in coal miners who smoke is considerably elevated, and smoking increases the effects of pneumoconiosis.

In work generating silica dust such as mining, rock drilling, chipping, grinding or stone polishing, smoking adds to the risk of silicosis, chronic bronchitis and chronic obstructive lung disease.

It has also been found that smoking increases both the prevalence and severity of byssinosis in the textile industry. In farming, a reduction in pulmonary function has been associated with grain dust and smoking.

Cigarette smoke not only increases the amount of cancer caused by radon daughters which are encountered in many mining and underground operations, but increases the rate at which the cancers develop.


Lung cancer death rates for cigarette smoking and/or exposure to asbestos dust compared to no smoking and no exposure to asbestos dust.
Cigarette smoker, Exposure to asbestos dust
Cigarette smoker, No exposure to asbestos dust
Non smoker, Exposure to asbestos dust
Non smoker, No exposure to asbestos dust
100
200
300
400
500
600
Source: Hammond, et al. Ann. New York Acad. Sci. (1979) 330, 467

(b) Chemical compounds associated with health risks are often found in both cigarette smoke and the working environment and each source augments the dose obtained from the other

Many gases and vapours occurring in cigarette smoke can also contaminate the atmosphere in various industries, for example: cigarette smoke is rich in carbon monoxide, found in many workplaces such as steel plants or ill-ventilated garages; formaldehyde, encountered in textile printing, foundries and laboratories; aliphatic aldehydes and ketones, found in the chemical industry, and work involving adhesives, lacquer and varnishes and paint spraying; acrolein occurring in the plastics, rubber and textile resins industries, and also a hazard of fire fighting; benzene and many other aromatic hydrocarbons and their derivatives found in the petrochemical, rubber, chemical, dyestuffs, detergents, adhesives and many other industries; ammonia and the oxides of nitrogen arising during fertilizer manufacture, in the chemical, paper and wood pulp industries, and in metal cleaning.

(c) Materials, transferred from the workplace onto smoking materials, which produce harmful materials when burnt during smoking

Many agricultural or industrial chemicals can come directly into contact with smoking materials, contaminate them and produce harmful effects when "smoked". For example, fluorine compounds used in sprays in certain industries can easily contaminate a cigarette and cause polymer fume fever which can lead to permanent lung damage.

(d) Occupational disabilities, such as those attributable to noise and vibration are enhanced by smoking

The prevalence of vibration white finger (Raynaud's phenomenon) in forestry workers has been linked with smoking. Smokers in noisy industry suffer greater loss of hearing acuity than non-smokers.

(e) Smoking material is often a threat to the safety of workers

Some worksites may present special problems with the issue of smoking whilst working; the risks of fire, explosions or pollution of the atmosphere are multiplied whenever tobacco is ignited. This applies to industrial sites but also to theatres and public transport such as aircraft.

Chewing is a very important form of tobacco use in the Indian subcontinent. It has also remained a practice among certain working groups in many countries, particularly when the nature of the working environment is such that smoking must be forbidden for safety reasons, as in coal mining and many sections of the chemical industry. It is also common in groups whose occupation requires the use of both hands leaving neither available to facilitate smoking. The fact that chewing tobacco also contains a large amount of harmful chemical compounds (e.g. nitrosamines) suggests that systemic effects can be expected.

IV. Passive smoking

Passive smoking is a unique risk for people, such as office workers, working in a closed environment. In the developed countries, tobacco smoke is the most common pollutant of indoor air and is usually present at higher concentrations than other air pollutants. Since most people spend a very high proportion of their time indoors, exposure to environmental tobacco smoke (ETS) is a serious health problem.

When hazardous materials are present in the workplace, non-smoking workers are also exposed to the same extent as are smokers and ETS could augment the effects of these hazards in the non-smokers. This particular effect of ETS can be illustrated by asbestos, the effects of which are greatly increased by tobacco smoke, because the likelihood of large numbers of people inhaling asbestos particles is, today, a consequence not only of working in a very wide range of industries but of urban life in general. ETS also substantially augments already existing indoor air pollution concentrations in the workplace of respirable particles and materials such as benzene, acrolein, N-nitrosamines, benzopyrene, nitrogen oxides and carbon monoxide. Thus the effects of passive smoking are superimposed on the detrimental effects on health of certain working conditions; the cumulative effects of hazards from the two sources being even more serious.

Important considerations in examining the risks of involuntary smoking (or passive smoking) are the composition of environmental tobacco smoke and its toxicity and carcinogenicity and the exposure (i.e. dose absorbed). Environmental tobacco smoke (ETS) has two constituents: *mainstream* cigarette smoke exhaled by the smoker and *sidestream* smoke, the smoke emitted by the burning tobacco between puffs. The comparison of the chemical composition of the smoke inhaled by active smokers with that inhaled by involuntary smokers suggests that the toxic and carcinogenic effects are qualitatively similar. However, as there is a greater dilution of sidestream smoke, greateramounts of many of the organic constituents of smoke, including some carcinogens, are generated when tobacco burns to form sidestream smoke than when mainstream smoke is produced. Furthermore, sidestream smoke particles are smaller than those of mainstream smoke and thus more easily reach all parts of the lungs.

The *health effects* associated with exposure to environmental tobacco smoke can be summarized as follows:

- Malignancy: Lung cancer.
- Respiratory symptoms and illnesses: Acute respiratory illness in early childhood; chronic cough, phlegm, and wheeze in children; chronic middle ear effusions in children; reduced levels and growth of lung function in children; reduced levels of lung function in adults; increased bronchial hyperresponsiveness (asthma); increased symptoms and decreased level of lung function in asthmatics.
- Irritant effects: Eye, nose, throat.
- Impaired childhood development: Low birth weight; slowed lung maturation; decreased attained height.
- Heart disease: Passive smoking increases the risk of coronary heart disease.

Individuals with preexisting health conditions, such as asthma, bronchitis, cardiovascular disease, rhinitis, colds and allergies, often report more severe reactions to environmental tobacco than do healthy adults.

Passive smoking and lung cancer

The most recent estimates of the relationship between passive smoking and lung cancer suggest that 20 to 30 per cent of cases with this disease in non-smokers derive from environmental tobacco smoke.

The International Agency for Research on Cancer (IARC) in Lyon, France, recently conducted a study on ETS exposure in 1 369 non-smoking women in 13 centres located in 10 countries (Canada, China, Germany, Greece, Hong Kong, India, Italy, Japan, Poland, and the United States). Exposure to ETS from spouses, at work, in public places, in vehicles and in any other indoor place were carefully investigated through a detailed questionnaire. Urine samples were collected and analysed for cotinine. Mean cotinine levels showed a clear linear increase from the group of women not exposed either at home or at work, up to the group of those exposed both at home and at work. Values were significantly higher for women exposed to ETS from the husband but not at work, than for those exposed at work but not from the husband. The results showed that the duration of exposure and the number of cigarettes to which the subject reported being exposed were strongly related to urinary cotinine. ETS exposure from the husband was better predicted by the number of cigarettes smoked per day, while exposure at work was more strongly related to the duration of exposure.

V. Smoking at work: an economic burden

Not only is smoking at the place of work injurious to the health of workers but it is a substantial economic burden to smokers, non-smokers, employers and society as a whole, and represents large avoidable expenses. Consequently, smoking control at the place of work will not only improve the health of workers but also reduce smoking-related costs such as those of:

- Direct medical care. In 1985, the US Department of Health and Human Services estimated that the total direct health care costs associated with smoking were US$ 34 billion per year.
- Absenteeism. In Canada it has been estimated that smoking employees are absent from 33% to 45% more than non-smokers.
- Fire, industrial accidents and the related increase for excess insurance costs. In 1984 in the United Kingdom, it was calculated that 6.5% of all fires on industrial premises arise from smoking materials. In Costa Rica in the first six months of 1991, 12.8% of all fires investigated were due to smoking material. In Brussels, after a fire in the chain store Innovation caused more than 300 deaths, the company enforced a complete ban on smoking in the workplace; according to data from the Brussels agglomeration one out of eight fires in 1984 was caused by smokers.
- Time spent on smoking. Not only will smoking decrease the productivity of smokers but it may disturb non-smokers and creates undue friction between workers.
- Maintenance. Smoking creates litter and necessitates more frequent renewal of decorations and furnishings, including filters in ventilation systems. Air Canada identified savings of about US$ 700 000 per year by not having to clean ashtrays and was able to extend the deep cleaning of its planes from six to nine months after implementing its tobacco-free policy.

Furthermore, smoking may limit the ability of workers to perform certain tasks and results in disability and early death. To these costs the unsuccessful special investments made by some employers in the hope of controlling tobacco-generated pollution of the air through various systems of air cleaning, should be added.

Atari recognizes increased productivity

At its subsidiary in the Federal Republic of Germany, Atari, the computer manufacturer, has for some time been giving six extra days of annual leave to its non-smoking employees.

Having decided at the beginning of 1985 to ban smoking in the workplace, the company provided some clearly-defined areas where those who so desired could smoke during two daily breaks of half an hour.

Since the overwhelming majority of non-smokers took no break and carried on working, the management decided a year ago to grant them an extra half day per month "non-smoker's" vacation.

The subsequent stage, beginning in July 1989, enabled the employees to take the monthly half days in two annual groups of three days' extra vacation.

Commenting on these measures, the Director of Personnel at Atari says, "We hope that our colleagues will benefit from this social advantage, and that much of their motivation will be the desire to preserve their health".

His wish, it seems, is being fulfilled, since almost 25% of the remaining smokers working at Atari have already given up their regrettable behaviour in order to qualify for the extra vacation.

VI. Tobacco smoke and ventilation in the workplace

Unlike homes, which usually rely on random ventilation, workplaces (industry or offices) are frequently equipped with complex ventilation systems. In reality, normal ventilation or air-conditioning is not enough to keep air tobacco-free. Air is usually recirculated for energy savings; recirculation avoids the costs of feeding through fresh air, which many have to be thermally and hydrologically conditioned. In general, filtration of indoor air does not remove environmental tobacco smoke contaminants effectively. Depending on the system and the season, up to 90% of used air may be recirculated. This air will be smoke-laden if there is smoking in the building. Filters remove dust but very few components of the cigarette smoke. The sub-micron particles and gases in cigarette smoke easily pass though filters used in normal ventilation and air-conditioning systems. These particles and gases are then recirculated throughout the building. Large, expensive air cleaners with high efficiencies for captured particles are capable of reducing, but not eliminating the environmental tobacco smoke particles in room air, and are not at all effective for gases, which contain most of the irritants. Thus, even expensive particulate air cleaners cannot remove enough particles in room air to eliminate the health risks from environmental tobacco smoke.

The workplace is thus often the place of greatest exposure for non-smokers. It also tends to be the place of longest involuntary exposure. In addition, non-smokers have least control over their environment at work, as most of them have to accept the conditions they find there. The recognition of this fact has prompted the progressive adoption of legislation and regulations.

VII. Tobacco-free workplaces and the law

Until recently many organizations that had introduced restrictions on smoking in the workplace had done so because there was a risk of fire, explosion or damage to property and equipment; as well as for hygiene considerations such as in the preparation of food. However, smoking and passive smoking are now recognized as causing health and safety risks that deserve to be overcome by a policy that provides tobacco-free air in the place of work. Such a policy will be implemented as various forms of regulations, whenever possible at the legislative level, but often as internal regulations at the place of work.

In the 1980s, laws and voluntary policies to restrict smoking at the workplace increased in number and strength. Some laws pertain only to government worksites; which, together with places of work where children are present, have often taken the lead. Others affect both government and private worksites. Present laws and policies are characterized by: banning smoking altogether, restricting smoking in common areas, such as cafeterias and meeting rooms; allowing smoking only in special smoking areas; and requiring accommodation of the interest of smokers and nonsmokers, with primacy given to the wishes of non-smokers. In addition, occupational health programmes are increasingly concerned with the synergistic effects of smoking and exposure to hazardous materials. These programmes may regulate smoking in worksites where hazardous materials are in use. For example, in 1976 Norway issued rules on protection against asbestos and prohibited assigning certain persons to work where they may be exposed to the effects of asbestos dust. These include persons under 18, persons suffering from chronic lung, bron-

New Zealand and the Smoke-free Environments Act 1990

In August 1990 New Zealand adopted comprehensive legislation for tobacco control. An important part of this legislation is the provision made for smoke-free indoor environments and, in particular, the measures proposed to prevent the detrimental effects of smoking on the health of people inside the workplace. Here are some highlights of these measures:

"...

5. Employers to have written policy on smoking:

(1) Every employer shall, within 3 months after the commencement of this Part of this Act, prepare a written policy on smoking for every workplace of that employer.

(2) In preparing the written policy, the employer shall consult with the employees affected, or with a representative of the employees nominated by them for the purposes of this Part of this Act.

(3) Every written policy prepared for the purposes of subsection (1) of this section shall be based on the principle that employees who do not smoke, or who do not wish to smoke in their workplace, shall, so far as is reasonably practicable, be protected from tobacco smoke in the workplace.

(4) Every written policy on smoking shall include, at the minimum, the following requirements:

(a) That smoking shall not be permitted:

(i) In lifts, or in office areas where more than 1 person works in a common air space; or

...

(iii) In any part of the workplace to which the public normally have access.

...

(c) The procedure for making complaints under this Part of this Act.

(5) The employer shall ensure that the written policy on smoking prepared for the purposes of subsection (1) of this section is reviewed in consultation with the employees or a representative of the employees at intervals of not more than 1 year.

..."

The law also envisages a system of investigations to deal with complaints in case of contraventions and determines fines in case of offences such as the failure by an employer to prepare a written policy on smoke-free premises.

chial, or heart disease, and persons who smoke. In 1988, Spain prohibited smoking in any place where a greater risk to the health of the worker exists from the combination of the harmfulness of tobacco and the prejudicial effects of industrial contamination. Spain also prohibits smoking in any occupational area where pregnant women work.

Increasingly, legislation restricting smoking at the worksite is expanding to cover private offices, factories, stores, and businesses. A number of countries (New Zealand, Norway and Sweden) have enacted such legislation at the national level. The 1991 French Law concerning tobacco and alcohol control prohibits smoking in all places designed for collective use, notably schools and means of public transport. Belgium, the Netherlands and Ireland have also passed laws prohibiting smoking in most public places. Other countries, such as Costa Rica, Cuba, Denmark, Iceland and Israel have taken legislative measures to restrict smoking in the workplace.

A noteworthy development in the effort to achieve tobacco-free worksites in the private sector has been the adoption and implementation of sub-national and local legislation and regulations. The experience of Canada and the United States illustrates this approach. In Canada, both provincial and municipal legislation limits smoking in private worksites.

The role of governments in developing such legislation is particularly important in countries where the harmful effects of tobacco consumption are not yet well known and/or where the health protection of workers is not yet well-established. Such legislation restricting smoking in the workplace will protect all workers, both smokers and non-smokers, particularly workers exposed to hazardous materials, and it will encourage people to recognize that exposure to environmental tobacco smoke at the worksite constitutes a negation of a safe working environment.

VIII. Promoting a tobacco-free workplace

Where basic working conditions are concerned it is still often *the role of the employees* to make it clear to management that change is both reasonable and necessary and that the dangers of tobacco consumption are real and immediate.

The tendency in many countries now is to admit that employees have both a moral and legal right to a tobacco-free workplace; and to the health and economic benefits not only of non-smokers but of smokers as well, and of employers. Surveys carried out in various types of worksites have confirmed this fact and have found that a majority of smokers would prefer a tobacco-free workplace.

Employees should be ready to defend their rights to a tobacco-free workplace; the law has been more and more on their side interpreting in the "tobacco-free" sense the obligation made in most countries for employees to have a safe and healthy place of work. In some countries cases of litigation in this area have confirmed, since the first case in 1976 in the United States (see box), the rights of employees to a tobacco-free workplace and awarded disability benefits, unemployment compensation benefits, injunctive relief and other judicial remedies to workers who suffer from exposure to smoke in the workplace.

Tobacco and the courts – the first US court case

In the 1970's a Bell Telephone Co. employee of 15 years' standing, with a good record, Donna Shimp, suffered severe allergic reactions even to low concentrations of tobacco smoke. She put up with it until she was transferred to a poorly ventilated office where seven out of 13 employees were heavy smokers. After a series of formal complaints to management, she was offered a job switch that involved a demotion and lower pay. Ms Shimp refused to accept what she considered to be a penalty. After exhausting all remaining grievance procedures, she launched a suit in the New Jersey Superior Court.

The judgment ordered Bell to provide Ms Shimp with safe working conditions, specifically by prohibiting smoking in its offices and customer service area. A key fact in persuading the judge to rule in Ms Shimp's favour was that the telephone company prohibited smoking near some of its sophisticated equipment; the judge said, "If such rules are established for machines, I see no reason why they should not be held in force for humans." What made the ruling so significant is that it was based, not primarily on Ms Shimp's allergy, but on common law principles applicable to non-smokers in general. Since the judgment has become a legal landmark in North America, it is worth quoting at some length:

"It is clearly the law in this state that an employee has a right to work in a safe environment. An employer is under an affirmative duty to provide a work area that is free from unsafe conditions. ... The evidence is clear and overwhelming. Cigarette smoke contaminates and pollutes the air, creating a health hazard not merely to the smoker but to all those around him/her who must rely upon the same air supply."

"The right of an individual to risk his or her health does not include the right to jeopardize the health of those who must remain around him or her in order to properly perform the duties of their jobs."

[Shimp v. New Jersey Bell, (App. Div. 1976)]

Promoting a tobacco-free workplace

In developed countries it has been shown that a larger percentage of the blue collar workforce smoked compared with white collar workers. In such conditions what is the stance taken by unions in smoking control in the place of work? Throughout the world trade unions have not been united in a single position on the issue. Some have not yet felt concerned about this important issue of workers' health; more specifically, there has been some opposition to discriminatory hiring practices against smokers and overreactive disciplinary actions against smokers. On the other hand, in many situations, unions have been fully supportive of workplace smoking policies and have even taken leadership roles. These actions reflect the union's recognition of cigarette smoking as an important health and safety issue.

In many countries the law makes it *the duty of employers* to provide and maintain a working environment for their employees that is safe and adequate as regards facilities and arrangements for the welfare of employees at work.

In recognition of these health and safety obligations and because of the growing demand for restrictions on smoking in the workplace from employees as nonsmoking increasingly becomes the societal norm, an increasing number of employers are introducing workplace smoking policies often in advance of any future legal requirements. Employers are also becoming concerned about labour and production cost increases, and the fact that if they do not act on passive smoking, they may be subject to litigation over time. Some companies and organizations also recognize that the introduction of a smoking policy enhances their corporate image. A review of such actions in some countries (Belgium, Canada, France, Germany, Greece, Italy, Mongolia, the Netherlands, Portugal, Spain and the United States) shows the creative strategies that companies have adopted, including prizes, bonuses, and extra holidays each year for nonsmoking employees equivalent to the time smokers take for smoking breaks.

An interesting way of recognizing the harmfulness of tobacco smoking at the place of work is the obligation imposed on employers in Japan by the revised occupational safety and hygiene regulations (with effect from 1 October 1988) to provide, within their health education programme, information on the biological effects of tobacco smoking.

Tobacco-free workplaces in the United States of America

The number of major companies restricting smoking in various workplace areas has risen from 16% in 1980 to 60% today. Of these:

- the proportion of companies which totally ban all smoking anywhere on their premises has jumped from 14% in 1988 to 25% in 1989
- today 38% of companies ban all smoking in their buildings, up from 25% just last year, and an additional 27% ban smoking in open offices, 30% in meeting rooms and hallways, and 31% in reception areas

[Smoking and Health Review, ASH, United States, 1991]

World No-Tobacco Day

IX. How to create a Tobacco-free workplace

Governments at all levels and the private sector are increasingly adopting or strengthening tobacco-free policies at the place of work. Over the past few years some elements have been found critical for success in the elaboration and implementation of such policies:

- the first is to provide the right information to employers and employees on the dangers specific to the place of work concerned, linking the particular occupation and smoking.
- employee participation in the elaboration of the policy is a key to its implementation, while top management support is a condition to its follow-up. Ideally, a joint working group comprising representatives of management and employees, of smokers and non-smokers, should be set up to steer the development of the policy from the initial opinion survey to its implementation.
- prior notice of the forthcoming policy or a phasing-in period is important to allow changes of attitude; simultaneously, smoking cessation programmes should be offered.
- finally, the continuous administration of the policy includes, after its adoption, universal enforcement within the premises and possible adaptation and whenever necessary strengthening, over time.

Numerous practical guides, adapted to the special socio-economic and cultural background of individual countries, on how to create a tobacco-free workplace, have been elaborated on the basis of the current legislation and regulation in these countries. General principles on how to create a tobacco-free workplace are common to most of these guides and can be summarized as follows:

1. **Develop a plan:**
   Obtain support from management and employees, provide adequate information, give advance notice and offer assistance with quitting. Emphasize the advantages to both management and employees. Establish a Working Group including a wide range of management and employees.

2. **Review present policy:**
   Review the current policy. Research the present facilities for suitability for being turned into tobacco-free areas.

3. **Establish overall objectives of policy:**
   A written, formal policy is preferred. Do not commit to a specific policy until employee opinion and information have been assessed. Explore all policy options such as effecting environmental alterations (separating smokers with physical barriers); restricting employee smoking, a range within these extremes:
   (a) smoking permitted except in designated no-smoking areas,
   (b) smoking prohibited except in designated areas; banning employee smoking at the worksite and preferential hiring of non-smokers.

4. **Plan an information campaign:**
   This should commence prior to circulating the questionnaire and continue throughout and beyond the policy implementation date. Approach the issue as a health problem. Emphasize that it is smoking that is being controlled, not smokers. The issue is not about whether people smoke, but where they smoke. No one is forcing a smoker to quit.

5. **Assess the views of the workforce:**
   Survey the staff to find out the ratio of smokers to non-smokers, their attitudes and recommendations. The best guarantee that a non-smoking policy will be successful is that it reflects as closely as possible the wishes of the workforce. Make it clear that comments will be considered and included in any final decision.

6. **The policy:**
   Keep the ban simple. Be clear where and when smoking is or is not allowed. Consider providing alternatives for those who cannot change their smoking pattern overnight. Reaffirm the policy for those who break restrictions.

7. **Provide assistance with quitting:**
   When an employer introduces a corporate smoking policy, smokers' needs must be considered. Support and counselling should be offered as part of the policy. This needs to be planned and the available materials and human resources ascertained.

8. **Implement the policy:**
   Set a date for starting – about 12 weeks ahead. Put up No-Smoking signs, etc. Smoking restrictions and bans are generally self-enforcing, but self-enforcement will not be effective unless the policy is clearly indicated by signs and other notices; signs announcing that policy should thus appear at every main entrance of the facility and for places where smoking is restricted to designated smoking areas, signs should indicate where the designated smoking areas begin and end. Make this policy known when recruiting new employees.

9. **Keep the policy under review:**
   Evaluate at regular intervals and refine accordingly.

X. Conclusion

The potential public health impact of smoking restrictions in the place of work is vast. Recognizing that the workplace is an inappropriate place to smoke will reinforce non-smoking as the social norm; it may also increase substantially the cessation rate of smokers, and thus make an important contribution towards reducing the prevalence of smoking in the world.

While it is the role of governments to pass and enact legislation prohibiting smoking at the place of work, the role played by individuals, employers or employees, as promoters and supporters of government action, has proved important. However, the role of employers and employees is not just to promote and support government action, but to motivate and enact voluntary action by companies to ban or restrict smoking even in the absence of appropriate legislation. Their success should be published and emulated. Resources have to be mobilized to support tobacco control at the workplace as smoking still kills a large number of workers in the world. These deaths are everyone's responsibility.

Primary sources of documentation:

World Health Organization – information emanating from the Tobacco or Health programme and from the International Agency for Research on Cancer; International Labour Office information, US Surgeon General Reports; documentation from the Environmental Protection Agency (United States), the U.K. Health Education Authority, the Asian Consultancy on Tobacco Control and numerous nongovernmental organizations involved in tobacco control at the place of work.

WORLD NO-TOBACCO DAY: WHAT ARE WE ACHIEVING?

The extent of the coverage given to World No-Tobacco Day 1991 confirmed for WHO that the message "Public places and transport: better be tobacco-free" had reached a large percentage of the world population. Reports already received at headquarters reflect a sense of efficacy in the measures taken for the celebration of the day, and confirm that World No-Tobacco Days are an important part of the tobacco control promotion that, in some countries, has seen a real decrease in the number of smokers and that it is a prime instrument for public information.

The long-term evaluation will of course be the legislative measures that have been taken to reduce smoking in public places and on public transport. Already it can be said that a number of governments and local authorities selected 31 May 1991 to officially announce or enact measures to prohibit smoking in public.

Furthermore, the significance of the day will also be measured by the number of people who have remained non-smokers even after World No-Tobacco Day has passed and by the number of people who have been protected from passive smoking due to the concerted action of WHO, governments and local organizers of these events.

The reports already received indicate that the *material produced by WHO for World No-Tobacco Day 1991* was extensively used. Information released for the day can be found in magazines, newspapers and various leaflets and pamphlets sent by individual countries. Amongst the material produced by WHO, specific mention has to be made of the poster which has not only been reproduced in innumerable articles but has also been modified to bear the specific names of countries, organizations, towns and local transport authorities; this was subject to agreement on the design. The poster was also "pirated" by several entities who replaced some of the famous buildings depicted on the poster with their own local buildings.

The theme chosen for World No-Tobacco Day 1991 was particularly easy to celebrate and local transport authorities, air carriers, national transport authorities easily picked up on the theme and gave it wide visibility through various events. Furthermore, this year's celebration received a mixture of support from scientific and lay backgrounds, e.g. universities, professional journals, daily newspapers or magazines and even children's comics.

Media coverage for the 1991 celebration of World No-Tobacco Day appears to have been more widespread and more detailed. Some countries have produced complete press reviews showing an extraordinary coverage by the press and audio media.

A selection of special events which took place to celebrate the fourth World No-Tobacco Day, 31 May 1991

"Public places and transport: better be tobacco-free"

Due to the advance production of this advisory kit information has only begun to flow in with reports of the celebration of World No-Tobacco Day 1991 in individual countries. However, from the reports already received it is interesting to see that there is a propagation of ideas from country to country on the methods of celebration of the World No-Tobacco Day*. We hope that the examples given below will assist other countries in the planning of future celebrations.

* *A more detailed analysis will be published by WHO in early 1992.*

AFRICA

Algeria

In order to have widespread impact special emphasis was put on local celebrations and on the media. The Ministry of Health instructed directors of health services and social protection of all the wilayas (departments) to ensure a proper celebration of the day. It produced and published its own material which included a poster on passive smoking.

Extensive coverage was given to the theme of the day on all radio stations. A special TV spot was prepared based on the poster and a special documentary film was broadcast on national television on 31 May 1991. The TV coverage was also extended to the national news bulletin. A large number of interviews and editorials appeared in the local newspapers in French and Arabic.

THE AMERICAS

Brazil

To sensitize the population the Brazilian Ministry of Health distributed information sheets in public places and airports on 31 May 1991, urging people to avoid smoking in public places and reminding people of the laws, decrees and legislation to this effect already existing in Brazil; particular emphasis was placed on Order No. 731 promulgated for last year's World No-Tobacco Day.

The Brazilian media gave nationwide coverage to the day with live interviews and reports. The general emphasis was on what was happening in the public transport area.

On 31 May 1991, the coordination of cancer control programmes of the National Cancer Institute launched a campaign against smoking in public places and public transport and, with the support of the taxi drivers' union, distributed 30 000 "Thank you for not smoking" stickers to the taxi drivers in Rio de Janeiro. Educational folders were also distributed.

The Ministry of Health published a booklet on cessation methods for physicians in order to encourage them to influence their patients.

EASTERN MEDITERRANEAN

Pakistan

In Pakistan a large number of functions were held under the auspices of the national health authorities and presided by high level officials of the Ministry of Health and of the UN system. The written press covered the events of the day thoroughly; a large amount of the press information cited the high rate of smoking in certain areas of Pakistan. The appeal of the Director-General of WHO was widely reproduced by most of the newspapers. A seminar on the hazards of tobacco consumption was held prior to the World No-Tobacco Day by the Anti-tobacco Addiction campaign. Anti-smoking associations staged rallies where children participated.

EUROPE

France

The Minister of Health and the Comité français d'éducation pour la Santé issued a special survey on the evolution of smoking tendencies in France within the perspective of the adoption of the new law against smoking; a press conference was held to present the findings. The Ministry of Health, and the national Social Security and Social Insurance promoted activities aimed at reducing tobacco smoking in public. The Caisse nationale de l'Assurance maladie, thanks to its network (150 local and regional respresentations), was one of the prime instigators of the day. Various departmental and municipal health committees organized celebrations and competitions. A number of private enterprises also selected that day to declare their non-smoking policies.

The major television networks broadcast special programmes on the subject. There was exceptional coverage of the day by the radio stations and by the written media (more than 200 articles were published in the national and regional press).

SOUTH-EAST ASIA

Bangladesh

Despite the natural disaster experienced in Bangladesh just prior to World No-Tobacco Day 1991, the day was celebrated in all parts of the country. The circumstances gave rise to special posters stating "Take your tobacco money to the distressed". On the night of 30 May 1991 a television programme, in which leading people in public places and transport centres were interviewed, was broadcast. Messages were received from the President of the People's Republic of Bangladesh, the Prime Minister and the leader of the opposition. These messages were published in the newspaper and broadcast on electronic media.

Nurses and medical students who had been briefed were key partakers in the celebration of the day. Processions took place in the streets of Dhaka and other cities.

With 31 May 1991 falling on a Friday, the Imans of the national mosque addressed the congregation on the topic of the day with quotations from the holy Koran which strongly prohibits addiction of all types.

At a seminar organized at the press club, the Minister for Education and Cultural Affairs stressed the need for spreading education among the people to make them aware of the adverse effects of smoking; the Ministry of Health and Family Welfare and the anti-smoking association Adhunik were also involved.

Wide publicity was given in all the media, both print and electronic, and a large number of stickers and posters were evident in lifts, trains, offices, meeting places, etc.

WESTERN PACIFIC

Papua New Guinea

Prior to the celebration of World No-Tobacco Day 1991 seminars were held on tobacco abuse and education. An exhibition took place featuring tobacco education posters, brochures, non-smoking stickers and other materials; a new video on smoking and health was produced. A circular letter from the office of the Secretary of Health was distributed to all provincial health departments urging activities in observation of the day with an attached copy of the article of the WHO Regional Director for the Western Pacific.

On the day, material was distributed in English, and in Tok Pidgin; special programmes were produced for the radio and television.

For World No-Tobacco Day 1991 the National Health Education Advisory Committee of Papua New Guinea received a Tobacco or Health medal as an example of effective coordination among various sectors in its campaign to stop smoking.

WHO and the UN system

While the celebration in individual countries is the main purpose of the World No-Tobacco Days, the day was also marked, as in previous years, at WHO headquarters and in the regional offices. This celebration included the awarding of Tobacco or Health medals to individuals and institutions within the health field, who were selected for continuing commitment for research and/or health promotion activities at national and international levels and to individuals and institutions outside of the health field cited for achievement worthy of international recognition in promoting the concept of tobacco-free societies. In some cases this was completed with panel discussions, official ceremonies, press conferences and the screening of the WHO video produced for the day.

A special feature of this year's celebration was the extensive participation of the *United Nations information centres* throughout the world. They relayed information provided by WHO to individual countries and in a similar fashion transmitted details of events in countries back to WHO.

As in previous years all UN agencies, and particularly the VIC Centre in Vienna staged celebrations of the World No-Tobacco Day. Furthermore, this year a number of agencies of the UN system used the theme of the day to reinforce and extend their regulations regarding anti-smoking policies at the workplace.

Special mention should be made of UNDP which has reminded its country representatives and regional offices of the need to support and celebrate the day.

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Finally, the day was successfully celebrated thanks to the active involvement of a large number of *nongovernmental organizations*, who once again have proved to be essential and dynamic instigators in the World No-Tobacco Days.

WHAT IS THE IMPACT OF THE WORLD NO-TOBACCO DAY IN YOUR COUNTRY

On an individual basis:

WHO is encouraging countries to carry out "impact" evaluations of their World No-Tobacco Days. The first component of such an evaluation is to find out how many people stopped smoking and remained non-smokers. One of the best examples is still Norway where an evaluation was made through a survey on a representative population sample two weeks after the Day, and through extensive personal interviews made at random among daily smokers aged between 22 and 55 years one week after the Day. In summing up the results, it can be shown that 96% of the sample were aware of the existence of the Day and that one-third of the smokers acted upon it. It also shows that the role of the media was very important and that the World No-Tobacco Day in Norway had received a remarkable degree of attention with ensuing discussions among families, friends and colleagues, and a pronounced behavioural reaction among smokers. An interesting evaluation could be to select a large sample of smokers and conduct a survey two weeks after the Day to investigate how many have ceased smoking and repeat this survey after one year and again at intervals of four to five years during the next ten to twelve years.

The second purpose of the Day, vis-a-vis individuals, is to propagate information on the harmful effects of tobacco. Consequently, another "impact evaluation" that could be done would be to estimate the number of people reached by the news and information disseminated during the Day.

On a municipal, provincial or national basis:

At this level, it will be interesting to evaluate if the World No-Tobacco Day has triggered enough interest or has put enough pressure to warrant the passing of a law, bylaw, or regulation advancing the cause of tobacco-free societies. The attitude in major companies or public buildings (such as hospitals, schools or ministries) should also be considered.

Finally, the following questions will be useful to complement the evaluation of the World No-Tobacco Day on a large scale.

Has your government improved the official policy or programme addressing tobacco or health on the World No-Tobacco Day?

Has the amount of money allocated to the implementation of this policy/ programme been increased?

Has the enforcement of the anti-tobacco measures taken in your country been improved because of the World No-Tobacco Day?

Has public knowledge regarding the harmfulness of tobacco been improved on this occasion?

Has the social acceptability of tobacco decreased because of the World No-Tobacco Day?

Has the general attitude of the public regarding tobacco regulations been affected by the World No-Tobacco Day; if so, how?

Future World No-Tobacco Days

WHO sees future World No-Tobacco Days as opportunities, not only to ask people to stop smoking for one day, but also to initiate research on specific themes, publish information, and initiate action. Just a quick glance at the list of themes for future World No-Tobacco Days shows what course of action will be pursued.

If you have enjoyed reading this information for World No-Tobacco Day 1992: "Tobacco-free workplaces: safer and healthier", perhaps you can help us prepare future editions of the advisory kit by sending material which could be the basis of our text. Here are the themes for the next World No-Tobacco Days.

- **1993:** "Health services, including health personnel, against tobacco"
- **1994:** "The media against tobacco"
- **1995:** "The economics of tobacco control"
- **1996:** "Sports and the arts without tobacco"
- **1997:** "The United Nations and specialized agencies against tobacco"

Let's make the preparation for World No-Tobacco Day a global endeavour!

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We inform you, please inform us!

To improve the quality of the information material provided by WHO for future World No-Tobacco Days, we need your feedback. It would thus be much appreciated if you could forward to the WHO Tobacco or Health programme, after the celebration of the Day, a short description of the activities which have been organized in your country or region to mark the fifth World No-Tobacco Day. This description could be substantiated by pictures, posters and newspaper articles or any other material used. Some ideas for this evaluation are given on pages 21 and 22. In addition, we will be glad to receive any official evaluation of the relevance and effectiveness of the information material forwarded by WHO for the occasion and the advice given through this advisory kit and the regional offices or the WHO representatives.